Updated 4/98
Revised 8/01
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Triage Acuity Level Guidelines

PURPOSE:

To provide guidelines for the Triage Nurse to promptly identify patients presenting with immediate life and limb threatening conditions; to prioritize patients ensuring the appropriate level and timeliness of care. These are guidelines only. The nurse is expected to use his/her professional expertise and judgment when determining acuity levels.

DEFINITIONS:

Level 1: Patients who need immediate attention. These patients have extremely serious injuries or illnesses and who might die if they are not treated immediately, i.e. cardiac arrest, profound shock, severe respiratory distress, and multiple traumas. The ED MD will see these patients.

Level 2: Patients who need emergent treatment. These are patients wit serious injuries or illnesses who might deteriorate or suffer long term problems if they do not receive very prompt treatment, i.e. myocardial infarction, severe bleeding, severe fractures, moderate respiratory distress, severe pain. The ED MD will see these patients

Level 3: Patients who need urgent treatment. These are patients who have severe, but not immediately life threatening injuries or illnesses and who need to be treated fairly urgently, i.e. leg fractures, mild respiratory distress, moderate to severe pain. Generally, the ED MD will see these patients, but they may be seen by a provider in the UCC (see accompanying flow diagram).

Level 4: Patients, who need the skills of our staff, but do not need urgent treatment. These are patients who do not deteriorate if they have to wait for treatment, i.e. sprains, and strains without neurovascular compromise, earaches, pink eye, simple cuts (no suturing required), simple UTIs, vaginal discharge. A provider in the UCC generally sees these patients during its hours of operation.

Level 5: Patients who do not need our skills or could seek attention from their own primary provider, i.e. long term problems including second opinions, coughs and colds, medication refills, STD contacts, minor rashes. A provider in the UCC generally sees these patients during its hours of operation.

The nurse should use the following time frames as a guideline when assigning triage levels:

Level	Time to Nurse Assessment	Time to Provider Assessment
1.	Immediate	Immediate
2.	Immediate	15 minutes
3.	15-30 minutes	30 minutes
4.	60 minutes	60 minutes
5.	120 minutes	120 minutes

The following flow diagrams and examples of triage levels should additionally guide the triage nurse.

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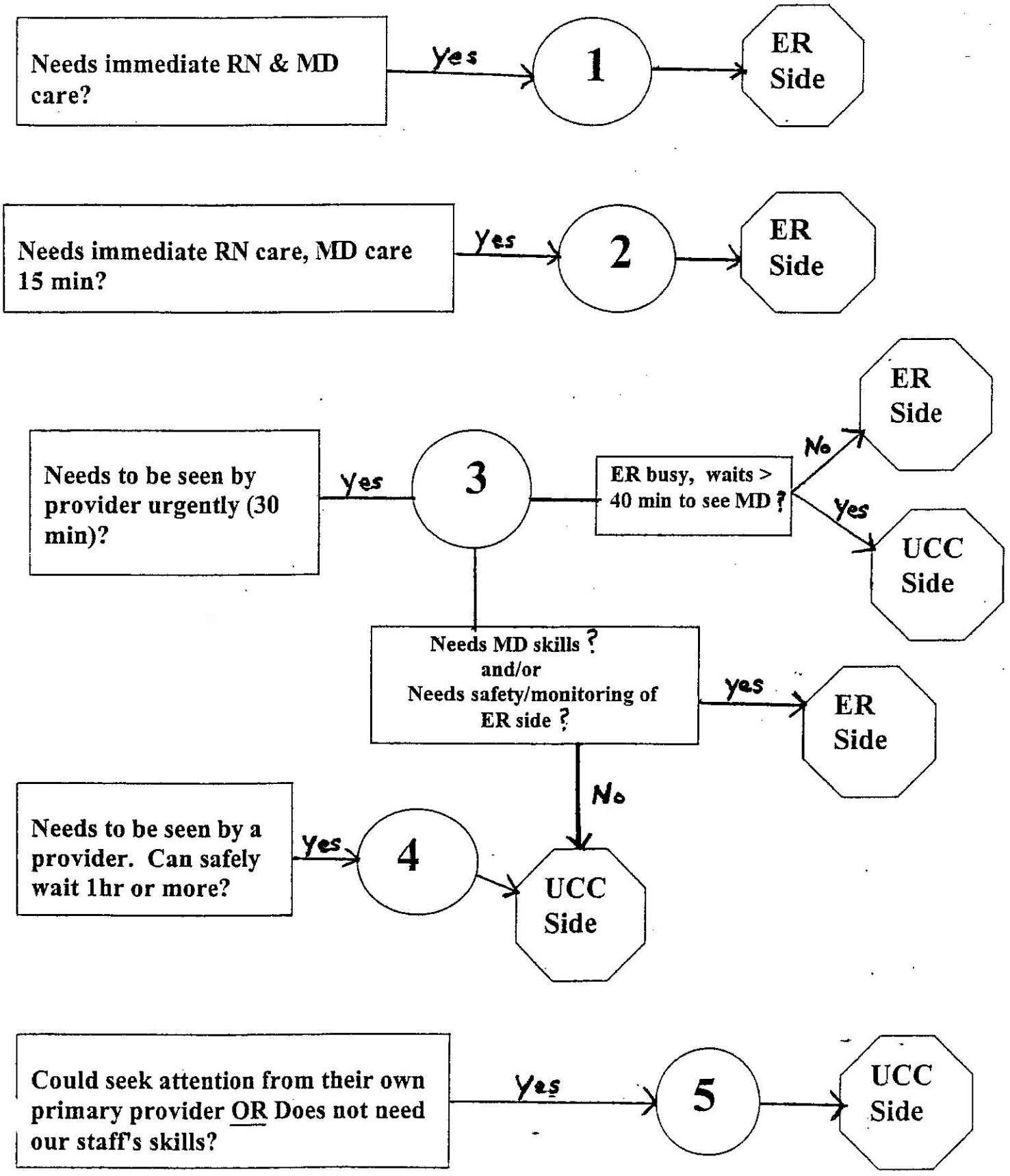
Triage Acuity Level Flow Diagram



Examples of Triage Acuity Levels (not exclusive list)

Level 1

- Cardiopulmonary arrest
- Severe respiratory distress--cyanosis, stridor, inability to speak, O2 sat< 90%
- Shock--hypotension, tachycardia, ↓ mental status, diaphoresis, etc. any etiology
- Multiple trauma, unstable
- GSW or large lacerations w/uncontrolled bleeding, life threatening
- Uncontrolled bleeding, life threatening